

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050085

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12511

STATE FILE NUMBER

FILED DEC 27 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

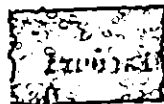
INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 1526 N. 16th St.	
3. NAME OF DECEASED (Type or print) First Ella Middle Whitney Last Whitney		4. DATE OF DEATH Month 12 Day 16 Year 63	
5. SEX Fem.	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-16-1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Hollisdale, Miss.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bertha Wilson		Address 4442 West Bell	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Cervix DUE TO (b) Uremia DUE TO (c) 171X		INTERVAL BETWEEN ONSET AND DEATH Undet.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 4:50 a.m. 4:50 p.m. Month, Day, Year 9-4-63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis
21. I attended the deceased from 9-4-63 to 12-16-63 and last saw him/her alive on 12-16-63 Death occurred at 4:50 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS 2601 N. Whittier St.	
22a. SIGNATURE Wm. S. Smith M.D.		22c. DATE SIGNED 12-16-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/20/63	23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	23d. LOCATION (City, town, or county) Mo.
24. FUNERAL DIRECTOR McClain Funl. Home		25. DATE RECD. BY LOCAL REG. DEC 18 1963	
ADDRESS 1841 Cass Ave.		26. REGISTRAR'S SIGNATURE Loan Smith M.D.	



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wallace R. Williams

Licensed Embalmer No. 4926

P. O. Address 5135 Route

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license):

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.